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Allyson Lynn Mazzuchi
Therapist Self-Disclosure:
a Current Look at Therapists'
Attitudes and Practices

ABSTRACT

This study was undertaken to examine the current views of therapist self-disclosure among clinicians practicing in the field today. The study examined what factors effect self-disclosure, such as a therapist's years of experience, the population they are working with and their own experience in therapy.

Therapists who participated had to have a minimum of five years working in the mental health field. Sixty-two therapists participated by filling out an anonymous survey. Therapists rated how often they used self-disclosure. Next therapists answered questions regarding how and when they decided to use self-disclosure and what their own experiences were with self-disclosure in their training programs and personal therapy.

The major finding of the study was that the majority of therapists use self-disclosure at some point. This finding substantiated findings from previous literature that therapist self-disclosure is a tool that is utilized in the field. Further investigation is needed with a larger sample to gain more insight into how this powerful is used in the field.

THERAPIST SELF-DISCLOSURE: A CURRENT LOOK
AT THERAPISTS' ATTITUDES AND PRACTICES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER ONE

INTRODUCTION

Self-disclosure by a therapist happens all the time in the therapeutic relationship. Sometimes it is intentional, such as disclosing personal information about the therapist or the therapist's feelings about the client, and sometimes disclosure is unintentional, such as how the therapist dresses or how the office is decorated. For the purpose of my study I examined intentional self-disclosure. Intentional self-disclosure, for the purpose of my study, was when a therapist makes a thoughtful and purposeful disclosure of information to the client, either regarding factual information about themselves, or about their subjective feelings about or towards a client.

Past research regarding how self-disclosure affects the treatment relationship was from the client's perspective or was analogue in nature (Hill & Knox, 2001). Far fewer studies have been done from the perspective of the clinician, and most were conducted in the nineteen-eighties and nineties, and so may not reflect the current attitudes of a newer generation of clinicians (Simone, McCarthy & Skay, 1998). It seemed that there was a need for a reexamination of how self-disclosure was being used in the field and who was using it.

The purpose of my study is to examine the current views of self-disclosure by therapists who are currently working in the field. I am interested in investigating whether or not therapists use the technique of self-disclosure, whether they use it more when working with children and adolescents, if therapists with more years in the mental health field self-disclose more or less and whether a therapist's own therapy experience in therapy has an impact on their use of self-disclosure.

CHAPTER TWO

LITERATURE REVIEW

Self-disclosure is considered a boundary issue, as it crosses an interpersonal boundary between the client and therapist (Zur, 2007). Appropriately and clinically driven disclosure and unavoidable disclosures are boundary crossings, whereas unnecessary and burdening disclosures which are boundary violations (Zur, 2007). Appropriate and clinically driven disclosure can promote more honest disclosure on the part of the client, in which openness can facilitate the working alliance (Papouchis, 1990). Conversely, disclosures that are not in the best interest of the client or which are used to gratify the therapist's own needs may cause damage or even disruption in the therapeutic relationship

There are various views on the use of therapist self-disclosure in therapy. The traditional psychoanalytical orientation called for the therapist to be a "blank slate" on which the client could project their feelings. (Mathews, 1988). This lack of self-disclosure was crucial to traditional psychoanalytical theory because it allowed the client to resolve the transference. Freud believed that the more the client knew about the therapist the less valid the transference would be because it would be tainted by the therapist's own ideas and feelings (Knox & Hill, 2003). Thus in the traditional psychoanalytical orientation the client knew little of their therapist as a person and there was little room made for self-disclosure on the part of the therapist.

In Object Relations treatment, the fundamental tool in therapy is the interpersonal relationship between the clinician and client. Through the relationship, the client is able

to take in a new positive self object that can be corrective (Papouchis, 1990). The therapist creates a holding environment for the client, creating a safe space for the client to explore his or her often painful past. This relationship cannot exist without therapists revealing something of themselves. The dyad that exists in therapy relies on the client trusting the space that is created between the two parties. In order to build that trust, the client needs to see the therapist as a good object to whom they can relate. This is something that self-disclosure may help to facilitate. From this perspective it is not the reliving of the client's old object relations that is helpful, but the creation of new relationships that can facilitate growth (Papouchis, 1990).

Ego-Psychology is also applicable to the topic of self-disclosure. Through self-disclosure, a clinician allows the client to borrow the therapist's ego until the client is able to strengthen their own. Self-disclosure normalizes the client's experience and allows them to feel understood. The experience of using the clinician's ego helps to integrate the client's own fractured ego. Self-disclosure always needs to be in the interest of the client and about shoring up and strengthening the individual client's ego.

Feminist theory posits therapist self-disclosure as an integral part of the therapeutic process. The core beliefs of feminist theory are to empower the individual and to lessen the imbalance of power (Brown & Walker, 1990). In the relationship of therapy there is an inherent imbalance of power as the majority of self-disclosure is traditionally done by the client. Feminist therapists believe that the increased use of therapist self-disclosure can shift this imbalance and create a space where clients are able to grow and make meaning of their lives (Brown and Walker, 1990). This self-disclosure includes

making the therapist's own values known and being open to discussion and debate with the client. Clients are encouraged to know their therapist's ethnicity, class background, sexual orientation and political values and to find therapists who are similar to them in any of these areas (Brown and Walker, 1990).

There have been several difficulties in the use of self-disclosure in the feminist tradition. One is that there has sometimes been a blurring of boundaries between therapist and client, at times causing attention to shift from the client to the therapist. (Brown and Walker, 1990). Another problem is that initially feminist therapists were using self-disclosure with no training or role models of how to use the technique appropriately (Brown and Walker, 1990). Some feminist therapists have also had difficulty creating their own personal boundaries due to the importance feminist theory places on the client knowing the values and beliefs of their therapist. Another problem has arisen with the use of self-disclosure as it has sometimes encouraged therapists to overgeneralize from their own experiences and project this view onto their clients (Brown and Walker, 1990).

Despite the differences in theoretical orientation, self-disclosure appears to be a technique that is employed by most therapists on some level (Zur, 2007). In a national survey looking at the use of self-disclosure over 90% of therapists surveyed responded that they used the technique of self-disclosure at some point in time (Pope, Tabachnick & Keith-Spiegel, 1987). The survey was distributed to 1,000 psychologists who were randomly selected from the 1985 Directory of American Psychological Association. Another study done by Mathews (1989) of 346 licensed psychiatrists, psychologists and social worker and found that over 80% reported using self-disclosure as an intervention.

Given the high rate of usage self-disclosure is a topic that needs to be carefully investigated.

Several studies have examined what level of self-disclosure is expected by clients. Merluzzi, Banikiotes and Missbach (1978) found that therapists who disclosed less often were perceived to be more expert than those therapists who disclosed more often. In contrast, McCarthy (1982) found that therapists who self-disclosed more often were seen as being more trustworthy than those who self-disclosed less frequently. A study done by Peca-Baker and Friedlander (1989) found no difference in clients' perceptions of low versus high self-disclosing therapists.

In her study of therapists' views of self-disclosure Mathews (1998) examined when and why therapists disclose to their clients and what effect therapist self-disclosure has on the treatment relationship. A survey distributed to 242 therapists aimed to assess how and when therapists disclosed. While the study used a mixed method design, the quantitative component was not thoroughly discussed in the article, making it difficult to determine the efficacy of self-disclosure. The article did lay out responses put forth by individual therapists regarding their views on self-disclosure, which might prove useful in designing further studies on the topic.

Kelly and Rodriguez (2007) examined the topic of self-disclosure from the vantage point of a client's symptomatology. Based on an earlier researcher's hypothesis, the study proposed that clinicians would disclose more to clients with greater levels of symptoms because these clients might have a harder time making a connection. It was believed that disclosure on the part of the therapist might bridge this gap. The study

interviewed both clinicians and their clients using several different measures. The clients were administered the Basis-32 and the Working Alliance Inventory, while the clinicians received the short form of the Working Alliance Inventory (Kelly & Rodriguez, 2007). Contrary to their hypothesis, their results revealed that clinicians actually did disclose more with clients who have *lower* levels of symptomatology (Kelly & Rodriguez, 2007). The limitation of the study was that it relied solely on clinicians' self-reports and did not have any way of validating the findings externally.

There is much discussion over whether self-disclosure on the part of the therapist is appropriate with clients who have low ego strength, such as found with axis II disorders. Some researchers report these clients are less likely to benefit from self-disclosure on the part of the therapist because these individuals have a hard time with boundaries to begin with and may become confused because self-disclosure shifts the structure of the relationship between therapist and client (Simon et al., 1998). With this type of client, therapists often limit disclosures to concrete statements such as that they will be on vacation, and tend to avoid abstract statements (Simone, et al., 1998). Weiner (1983) suggested that clients with less ego strength need help from their therapist to experience the world as it actually is and not as they perceive it, but may not be capable of integrating the therapist's self-disclosure in a way that is healthy and helpful. It has also been hypothesized that therapists disclose more to clients that are similar to them and that this connection may not be present with patients with more severe mental health issues (Kelly & Rodriguez, 2007).

Another issue that is important to examine is what effect a therapist's own experiences with therapy has on their use of self-disclosure. In a study done by Simone et al. (1998) therapists were asked about their personal experience in therapy. The study found that those who reported a helpful disclosure by their therapist reported a significantly greater likelihood that they would use self-disclosure with their clients (Simone et al., 1998). Other research has found a link between the amount of personal therapy and the rate at which therapists disclose. A study done by Simon (1988) looked at how high and low self-disclosing therapists view personal therapy and found that high self-disclosing therapists had considerably fewer hours of personal therapy. Simon (1988) concluded that self-awareness was more a fundamental part of how low disclosing therapists operate within the therapeutic relationship. It is hard to generalize these findings both because the sample was so small, eight therapists, and the therapists used in the sample were at the extreme ends of the spectrum of self-disclosure.

A study done by Jeffery and Austin (2007) examined the perspectives on self-disclosure of clinical social workers versus marriage and family therapists. Surveys were mailed to 500 clinicians, 250 of them clinical social workers and 250 of them marriage and family therapists. Of the 500, only 73 clinicians responded, for a 16% response rate. Two of the statements presented to the clinicians had significant relevance. On the whole there was a significant difference between responses of the clinical social workers and marriage and family therapists around how they viewed self-disclosure (Jeffery & Austin, 2007). Clinical social workers were more likely to agree with statements that indicated self-disclosure about oneself weakens the therapeutic relationship, while marriage and family therapists agreed that self-disclosure encouraged an atmosphere of honesty. The

limitation of the study was the low response rate that the researchers got to their survey. Despite this it is worth further investigation to look at how a clinician's beliefs around self-disclosure are formed.

The issue of self-disclosure around sexual orientation is an issue that very commonly affects gay, lesbian and bisexual therapists. Historically, in the traditional analytic perspective, the analyst was assumed to be heterosexual (Cole, 2006). While this assumption is still widely held, many therapists have begun to come out both publicly and to their clients, and the dilemma around how to make this disclosure is important to discuss. Sexual orientation is uniquely different from racial or ethnic identity because members of those groups usually grow up in families that mirror their racial and ethnic identity and provide a safe and accepting environment. Gay, lesbian and bisexual individuals are often brought up in environments where their sexual orientation leaves them isolated and misunderstood because they have no role models that their identity is normative. This is the reason that self-disclosure on the part of the gay therapist can be so important during the course of treatment of a gay client, as the therapist can provide role modeling and reduce the shame of being gay (Guthrie, 2006). Like any other disclosure, revealing one's sexual orientation will not be right in every circumstance. Premature disclosure can rupture the treatment alliance and confuse the client. It is important to first grapple with what the meaning is for a particular client at a particular point in time (Guthrie, 2006).

Several studies have shown that many gay and lesbian clients prefer a clinician who is of the same sexual orientation. McDermon, Tyndall and Lichtenberg (1989)

found that nearly half of gay and lesbian respondents preferred to see a gay or lesbian counselor. In another study done by Modrcin and Wyers (1990) 40% of gay and lesbian respondents said they would only seek help from someone with the same sexual orientation as themselves. Another study done by Bradford, Ryan and Rothblum (1994) found that 66% of lesbians preferred to see a gay or lesbian therapist. Yet another national survey found that 40% of gay and lesbian clients had seen at least one therapist who was gay, lesbian or bisexual (Liddle, 1997). Given these findings, the decision for a gay or lesbian therapists' decision to self-disclose their sexual orientation is an important one that can affect whether a gay or lesbian clients is able to decide whether they see a therapist who is similar to them in sexual orientation. The issue of a therapist's sexual orientation seems to come up most commonly in the beginning of treatment. In her study of 392 gay and lesbian clients, Liddle (1997) found that 63% of therapists are pre-screened for gay-affirmative attitudes before gay or lesbian clients will begin treatment.

Self-disclosure is also important when working cross culturally. Burkard, Knox, Groen, Perez and Hess (2006) examined how European-American therapists have used therapeutic self-disclosure in their work with clients from different racial and ethnic backgrounds. The study was qualitative in nature and used interviews to discern when European-American therapists used self-disclosure and what effects it had on the treatment relationship with their minority clients. Eleven therapists were interviewed and detailed accounts of their cross-cultural self-disclosure were recorded. The findings revealed that therapists self-disclosed for many reasons including in order to validate clients' experiences of racism, be authentic regarding the clinician's own struggle with racist beliefs and attitudes and sharing their own cultural biases or perspectives (Burkard

et al., 2006). The clinicians in the study revealed that there was generally an improvement in the therapeutic relationship. Clinicians reported that many clients were more trusting of them after a self-disclosure, while others revealed that clients were able to discuss more intimate issues (Burkard et al., 2006).

Another section of the population that needs special consideration is composed of children and adolescents. Therapy with children and adolescents is less about resolving transference and more about providing new objects that the child can internalize (Gaines, 2003). Children and adolescents tend to think more concretely than adults. For this reason, they may experience the therapist's expression of feelings or ideas as being true (Gaines, 2003). It is important to be more direct with children because their questions are often about figuring out the way the world works, and answering a child in an honest and straightforward manner can facilitate a child's ability to master reality (Papouchis, 1990).

Children's questions about their therapists may also have hidden meaning. For example, they might want to know if their therapist has children, but beneath this question may lie the deeper meaning of "do you care about me?" (Gaines, 2003). In their study of therapist self-disclosure to child patients, Capobianco and Farber (2005) found that the most frequent piece of information that therapists self-disclose to children is their parental status. This is in part because unlike for adult clients, the child client's parents are not just fantasy figures but real life objects that the child continues to interact with and depend on in everyday life (Papouchis, 1990). The therapist enters into this situation and has the capability for becoming a new object who can contribute significantly to the child's development (Papouchis, 1990).

Therapists also serve as role models for children and adolescents when they self-disclose by modeling what they are asking of the child or adolescent. Therapist self-disclosure helps normalize the child's experience and encourages reciprocity (Capobianco & Farber, 2005). In therapeutic work with children there is much more pretend play, (especially with young children), that inevitably lends itself to the therapist revealing part of themselves. There is a fair amount of educating and limit-setting that happens in therapy with children, which allows the child to be privy to the therapist's belief system in a way often does not occur with adult clients (Papouchis, 1990).

Adolescents also inherently need more from their therapists because they are at a crucial time of personality development. Adolescents are trying to separate from their parents and enter into adulthood and need an adult who can "hold" their dual status as both child and adult. Therapists who work with adolescents have the job of helping the adolescent establish autonomy without recreating the dependent relationship the adolescent has with his or her parents (Papouchis, 1990). The therapist must be prepared for intense scrutiny from his or her adolescent client as the adolescent searches for alternative models of what it means to be an adult. In order to create a therapeutic alliance with the adolescent the therapist must be willing to be authentic and genuine (Papouchis, 1990). This often means not being evasive to direct questions and being willing to help the adolescent problem-solve. Given the level of realness needed by adolescents in order for them to engage in treatment, some self-disclosure is inevitable.

While many studies have supported the use of self-disclosure among therapists, Bishop and Lane (2002) explored the idea that self-disclosure was a technique best used

by experienced clinicians. Even though the humanist engagement of self-disclosure allows healing to happen, novice clinicians are warned to make sure they have a good grasp of the traditional psychodynamic framework before attempting to use the technique. The ramifications of misguided self-disclosure can create damaging and lasting effects on the client. Bishop and Lane (2002) posited that when the psychodynamic frame is maintained, it is easier for the therapist to attend to the phenomenon of transference. This transference is essential for the work of therapy to happen and often holds the key to helping individuals resolve their conflicts.

Another issue that needs to be considered when therapists self-disclose is that the content of their self-disclosure is not confidential. The unilateral direction of confidentiality protects the client and allows them some power in the therapeutic relationship. The asymmetry of confidentiality allows a place for the therapist to discuss what it means for them to disclose (Sweezy, 2005). This can open up a dialogue between client and clinician and allow the modeling of personal safety and limits. This demonstration shows the client that the clinician is vulnerable rather than invulnerable and can demystify the power of the clinician in a healthy way (Sweezy, 2005).

Previous literature has showed that self-disclosure is a technique used by a variety of therapists and is not necessarily dependent on their theoretical orientation. While it is commonly agreed that some form of self-disclosure is helpful, how or when self-disclosure is used is still untested, making self-disclosure more of an art form than a science. Appropriate use of self-disclosure also varies depending on the population one is working with. Much of the literature has shown that clients who may be marginalized or

disempowered such as minorities, GLBT or child clients may need special consideration regarding therapist self-disclosure.

Overall self-disclosure is an effective and powerful therapy tool that should be used with caution. The majority of therapists working in the mental health field today use some form of self-disclosure with their clients. Different clients require different levels of self-disclosure. Therapists working with children and adolescents need to use more self-disclosure than therapists working with adults. Children and adolescents are readily able to detect ingenuity. They often do not yet have the social constraints that prevent direct inquiry.

A therapist's own experience has an effect on their use of self-disclosure. Therapists with more years in the field are more likely to use self-disclosure more often because they have learned the delicate balance of how much self-disclosure is therapeutic for a given client. Lastly a therapist's own therapy experience has an effect on their use of self-disclosure. Therapists who have had a positive experience in therapy with a self-disclosing therapist are more likely to use the technique with their own clients.

CHAPTER THREE

METHODOLOGY

I investigated the current views on techniques of self-disclosure used by therapists working in the field today, using a quantitative, anonymous internet survey design study. My research questions were:

Do therapists currently working in the mental health field self-disclose to their clients?

Do therapists working with children and adolescents self-disclose more than therapists working with adults?

Do therapists with more years working in the mental health field self-disclose more or less?

Does a therapist's own experience in therapy have an impact on their use of self-disclosure?

Participants in this study were therapists who had been practicing in the mental health field for at least five years. Therapists who had less than five years in the field were excluded. Therapists could be either professional or paraprofessional, from any discipline, including but not limited to: social workers, mental health counselors, psychologists and substance abuse counselors. The parameters of the sample size were at least fifty, but not more than two hundred, participants who were over the age of eighteen, were able to read and write English, and were willing to fill out the survey over the internet using Survey Monkey. The Human Subjects Review Committee of Smith College School for Social Work approved my study (Appendix A)

I used a sample of convenience from the Western New England region. I sent flyers by e-mail and handed them out in person, to directors of local mental health agencies asking for their assistance in recruiting therapists to participate in my survey. I then got written agency permission to distribute my flyers to individual clinicians and submitted these written documents to the HSR committee. I also contacted practicing therapists that I knew in the community and asked if they or therapists they know would be interested in participating in my survey. When I contacted local mental health agencies and local practicing clinicians I handed out flyers that had the link to my survey (Appendix B). Therapists who were interested in taking the survey had to use the link to get my survey posted on Survey Monkey (Appendix C). Given that it was an anonymous survey I had little control over the diversity of my participants. However, I actively tried to outreach to clinicians of color in order to get the most balanced, diverse group of participants that I could. I utilized a snowball method and asked participants to forward the link for my survey on to colleagues.

There was an initial question asking participants if they have been practicing in the mental health field for at least five years. If they answered “yes” they were guided through my survey. If they answered “no” they were thanked for their time and were exited out of the survey. Participants were then asked to read a letter of informed consent and click on the “I agree” button to continue (Appendix D). I asked participants to print a copy of the consent letter for their records. Any participant that did not click the “I agree” button at the end of the informed consent letter was taken to a screen that thanked them for their time and they were not able to participate in the survey.

Participants were then asked for demographic information including their gender, age, racial/ethnic identity, marital status, highest level of education, professional discipline, type of license (if any), how long they have been working in the mental health field, and what population they work with.

Next, participants were asked whether they self-disclose when working with clients. If they answered “yes” they were guided to answer six questions on different aspects of self-disclosure. Participants who answered “no” to that question were guided to answer why they don’t use self-disclosure. All participants were then asked a question about whether self-disclosure was covered in their training program. They were asked if they have been in therapy and, if so, whether their own therapist ever self-disclosed. If they answered “yes” to this question they were asked how it affected their working relationship with their own therapist, and they were provided space to write comments about how it specifically affected their relationship.

Participation in the survey took approximately 10-15 minutes, though it may have taken longer if they chose to fill in the dialogue boxes. Data was analyzed with the assistance of the Smith College SSW Statistical Analyst using SPSS 15.001.

There was a small risk that by participating in my survey that therapists might have felt somewhat uncomfortable recounting times they used self-disclosure, especially if it resulted in a negative outcome with a client. In the Informed Consent letter I suggested participants seek support if they experienced distress while participating in the survey. Participants were informed that they could end the survey at anytime without penalty, but that once they click on the “submit” button the information could not be retracted because there was no way of identifying their information. The benefit of

participating in this study was that it gave therapists a chance to reflect on their use of self-disclosure. In addition, it contributed to the literature regarding the therapeutic use of self-disclosure.

CHAPTER FOUR

FINDINGS

The major questions that were addressed in this research project were:

Do therapists currently working in the mental health field self-disclose to their clients?

Do therapists working with children and adolescents self-disclose more than therapists working with adults?

Do therapists with more years working in the mental health field self-disclose more or less?

Does a therapists own experience in therapy have an impact on their use of self-disclosure?

Demographics of Participants

The participants in this sample were therapists who had been working in the mental health field for at least five years. 91 people responded to the anonymous survey that was posted on Survey Monkey. 19 people did not meet the inclusion criteria of having worked in the mental health field for at least five years. Of the 72 who did meet the inclusion criteria of having worked in the mental health field for at least five years, only 62 people agreed to the informed consent and were allowed to participate.

Age

The largest age group of participants in this study was individuals in the 46-55 age range. This age group represented 31% ($n = 18$) of the sample. The next largest group of participants in the study was individuals in the 36-45 age range. They represented 27.6% ($n = 16$) of the sample. Individuals in the 56-65 age range represented 22.4% ($n =$

13) of the sample. Finally, the individuals in the 25-36 age range represented 19% ($n = 11$) of the sample. The median age of participants in the sample was 47. The mean age of participants in the sample was 46.28.

Gender

The majority of the participants in this study were female. Women represented 78.7% ($n = 48$) of the sample, while men represented 21.3% ($n = 13$) of the sample.

There was a third choice provided on the demographic portion of the survey:

“transgendered” but no one selected this option.

Race

The vast majority of participants in this study identified as being Caucasian, representing 91.7% ($n = 55$) of the sample. People who identified as African-American were the second largest group at 3.3% ($n = 2$). People who identified as Latino/Hispanic and Native American represented 1.7% ($n = 1$) of the sample respectively. Lastly there was an option of “other” which comprised 1.7% ($n = 1$) of the sample.

Level of education

The majority of participants in the study had Master’s degrees. People who held Master’s degrees represented 82.0% ($n = 50$) of the sample. People who had Doctoral degrees were the next largest group, representing 16.4% ($n = 10$) of the sample. Lastly people who had held only a Bachelor’s degree were the smallest group, comprising only 1.6% ($n = 1$) of the sample.

Professional discipline

The majority of participants in the study identified as social workers, who made up 72.9% ($n = 43$) of the sample. There were an equal number of psychologists and mental health counselors. Each group made up 13.6% ($n = 8$) of the sample respectively.

Years in the mental health field

Almost three-quarters of participants in the study had more than 10 years of experience in the mental health field, making up 64.4% ($n = 38$) of the sample. Participants with 10 or less years experience in the mental health field made up 35.6% ($n = 21$) of the sample. The median length of time working in the mental health field was 15 years. The mean length of time working in the mental health field was 17.27 years.

Treatment setting

Almost two-thirds of participants in the study worked in outpatient clinics. They made up 62.7% ($n = 37$) of the sample. Those working in outpatient private practice made up 23.7% ($n = 14$) of the sample. People working in case management were the third largest group, making up 10.2% ($n = 6$) of the sample. Lastly, people working in residential programs made up the smallest group, 3.4% ($n = 2$) of the sample.

Population worked with

This section deals with the client population that participants currently work with. Participants were given three client age-range choices, and could choose as many as applies to their current practice. Children ages 12 or under are treated by 41.9% ($n = 26$) of the sample. Adolescents, ages 13-19, are treated by 41.9% ($n = 26$) of participants. Adults ages 20-64 are treated by 79.0% ($n = 49$) of participants. The last client-population survey choice was adults age 65 years and older. Only 11.3% ($n = 7$) of

participants indicated they work with adults 65 years and older. Clearly, many participants work with multiple age groups.

Survey Questions

Question 1: How often do you self-disclose with clients?

Just over half of participants, 54.1% ($n = 33$), responded that they periodically self-disclosed with clients. The next largest group of participants, 39.3% ($n = 24$), responded that they rarely self-disclose with clients. The last group of participants, 6.6% ($n = 4$), responded that they often self-disclose with clients. There was also an option to answer never but no one indicated this.

Given that the frequency of self-disclosure was the main topic of this study, I asked the question again with different answer choices. This time the largest group of participants, 51.0% ($n = 26$), responded that they self-disclose with clients sometimes. The rest of participants, 49.0% ($n = 25$), responded that they self-disclose with clients rarely.

Question 2: When do you use self-disclosure more often: in the beginning of treatment, during the middle of treatment or near the end?

Two-thirds of participants, 66.0% ($n = 31$), responded that they use self-disclosure more during the middle of treatment. About one-fifth of participants, 19.1% ($n = 9$), responded that they use self-disclosure more near the end of treatment. The smallest group of participants, 14.9% ($n = 7$), responded that they used self-disclosure more in the beginning of treatment.

Question 3: How does your current self-disclosure compare to your past self-disclosure?

Again, almost half of participants, 47.1% ($n = 24$), responded that they use self-

disclosure somewhat more often now than they had in the past. A third of participants, (33.3%, $n = 17$), responded that they use self-disclosure somewhat less often now than in the past. A small group of participants, 13.7% ($n = 7$), responded that they use self-disclosure extremely more often now than in the past. A few participants, 5.9%, ($n = 3$), responded that they use self-disclosure extremely less often now than in the past.

Question 4: How often do you self-disclose with clients who are the opposite sex as you?

Approximately two-thirds of participants, 66.1%, ($n = 37$) responded that they sometimes self-disclose with a client who is the opposite sex as themselves. The other third of participants, (33.9%, $n = 19$), responded that they rarely self-disclose with a client who is the opposite sex as themselves. There were “never” and “always” answer choices as well, but no participant indicated either of these answers.

Question 5: How often do you self-disclose with clients who are the same sex as you?

The large majority of participants, 67.9% ($n = 38$), responded that they sometimes self-disclose with a client who is the same sex as themselves. The minority of participants, 32.1%, ($n=18$) responded that they rarely self-disclose with a client who is the same sex as themselves. It appears that gender has little effect on how often therapists self-disclose to their clients. There were “never” and “always” answer choices, but no participants indicated either of these two answers.

Question 6: When you engage in self-disclosure, how often do those self-disclosures consist of factual information about yourself?

More than two-thirds of participants, 65.5% ($n = 36$), responded that their self-disclosures sometimes consist of factual information about themselves. The next largest group of participants, 29.1%, ($n=16$) responded that their self-disclosures rarely consist of

factual information about themselves. A few participants, 3.6% ($n = 2$), responded that their self-disclosures never consist of factual information about themselves, and just 1.8%, ($n=1$), of participants responded that their self-disclosures always consist of factual information about themselves.

Question 7: When you engage in self-disclosure how often do those self-disclosures consist of feelings and events in your own life?

Almost half of participants, 42.9% ($n=24$), of the sample, responded that their self-disclosure sometimes consist of feelings and events in their own life. A similar number of participants, (41.1%, $n = 23$), responded that their self-disclosures rarely consist of feelings and events in their own lives. Another group of participants, 14.3%, ($n = 8$), responded that their self-disclosure never consists of feelings and events in their own life. Only 1.8% ($n=1$) of participants responded that their self-disclosures always consist of feelings and events in their own lives.

Question 8: When you engage in self-disclosure how often do those self-disclosures consist of feelings about or towards the client?

Almost half of participants, 49.1% ($n = 27$), responded that their self-disclosure sometimes consists of feelings about or towards the client. The next largest group of participants, 36.4%, ($n=20$), responded that their self-disclosures rarely consist of feelings about or towards the client. The smallest group, 14.5% ($n=8$), responded that their self-disclosure never consists of feelings about or towards the client. There was an option for participants to answer that their self-disclosures always consisted of feelings about or towards the client but no one responded in this way.

Question 9: In your training program were there classes or lectures about the use of self-disclosure?

Most participants, (69.1%, $n = 38$) responded that there were classes or lectures in their training program about the use of self-disclosure. The minority of participants, 30.9% ($n=17$), responded that there were not classes or lectures in their training program about the use of self-disclosure.

Question 10: Have you ever been in therapy?

The vast majority of participants, 92.9% ($n = 52$), responded that they have been in therapy themselves. A few participants, 7.1% ($n=4$), responded that they have not been in therapy before.

Question 11 (this was asked was to only those participants who had indicated that they themselves had been in therapy): Did your therapist self-disclose to you?

The majority of participants, 81.1% ($n=43$), responded that their therapist had self-disclosed to them. The minority of participants, 18.9% ($n=10$), responded that their therapist had not self-disclosed to them.

Question 12 (This question was asked of those who had therapists who self-disclosed to them): How did it affect your working relationship?

The majority of participants, 63.8% ($n=30$), responded that it had a positive effect on their working relationship with their therapist. The next largest group of participants, 25.5% ($n=12$), responded that it had neither a positive or negative effect on their working relationship with their therapist. The smallest group, 10.6% ($n=5$), responded that it had a negative effect on their working relationship with their therapist.

Research Questions

Do therapists working with children and adolescents self-disclose more than therapists working with adults?

I attempted to determine if there was a statistically significant difference in the percentage of participants who disclose to children compared to their counterparts who self-disclose to adults, using Pearson Chi-Square analysis. Unfortunately, because of the size of my sample, resulting in fewer than 5 in more than 20% of cells, minimal requirements were not met, and results were not valid.

A Crosstab analysis was done to examine whether therapists working with children or adolescents disclosed more than therapists working with adults. The results indicated a similar distribution regardless of the age of the client, though therapists working with children and adolescents were slightly more likely to self-disclose: 62.5% ($n = 8$) of therapists working with children or adolescents responded that they self-disclose sometimes, while 60.0% ($n = 15$) of therapists working with adults responded that they self-disclose sometimes. On the other hand 37.5% ($n=3$) of therapists working with children or adolescents responded that they self-disclose rarely, while 40% ($n = 10$) of therapists working with adults responded that they self-disclose rarely.

Do therapists working in the field longer self-disclose more or less?

I conducted a T-test analysis to determine whether there was significant difference in the mean years of experience of therapists and whether they self-disclose rarely or sometimes. There was no statistically significant difference. A Crosstab analysis was run with therapists divided into those who had ten years or less of experience and those who had more than ten years of experience. The results indicated that therapists

who have 10 or less years in the mental health field tend to disclose less often, with 38.9% ($n = 18$) of them responding that they sometimes self-disclose. In comparison 56.3% ($n = 32$) of therapists with more than ten years of experience in the mental health field responded that they sometimes self-disclose. Therapists with less than ten years experience responded that they rarely self-disclose. While 43.8% ($n = 14$) of therapists with more than ten years of experience in the mental health field responded that they self-disclosed rarely. A Pearson Chi-Square test was run to determine if there was a significant difference in self-disclosure between therapists with less than ten years experience in the mental health field and therapists with more than ten years experience in the mental health field. No significance difference in rates of self-disclosure between the two groups was found.

Does a therapist's own experience in therapy have an impact on their use of self-disclosure with clients?

A Pearson Chi-Square test was run to determine if a therapist having been self-disclosed to during their own therapy has an effect on their use of self-disclosure with clients. The test was not valid because the assumption that E.F. should not be less than 5 in 20% of cells was not met.

A Crosstab analysis was done to see whether a therapists own experience with a therapist who self-disclosed to them affected their rate of self-disclosure. The results show that therapists, whose own therapists self-disclosed, self-disclosed more often with their clients: 55.3% ($n = 21$) of therapists who had a therapist who self-disclosed to them responded that they sometimes self-disclosed with clients. In comparison, 40.0% ($n = 4$) of therapists who did not have a therapist who self-disclosed to them responded that they

sometimes self-disclosed to clients. In contrast, 60% (n=6) of therapists who did not have a therapist self-disclose to them responded that they only rarely self-disclose to clients and 44.7% (n=17) of participants who did have their own therapist self-disclose to them responded that they only rarely self-disclose to clients. Because of this difference, it is possible that there is a relationship between having a therapist who self-disclosed, and using self-disclosure in one's own practice. The limited number of participants prevented this from being demonstrated statistically.

CHAPTER V

DISCUSSION

Overview of Study

The study design was a quantitative, anonymous internet survey. I was interested in investigating the current views of therapists working in the field on techniques of self-disclosure. My research questions were: Do therapists currently working in the mental health field self-disclose to their clients? Do therapists working with children and adolescents self-disclose more than therapists working with adults? Do therapists with more years working in the mental health field self-disclose more or less? Does a therapist's own experience in therapy have an impact on their use of self-disclosure?

Interpretation of Findings

My first research question examined whether therapists currently working in the mental health field self-disclose to their clients. The results showed that the majority of therapists do use self-disclosure with their clients. There was a difference in how often therapists used self-disclosure with about one-half (49%) of participants self-disclosing rarely and the other half (51%) self-disclosing sometimes. Though the difference was not big enough to be significant, it does indicate that many therapists currently working in the field of mental health are using some level of self-disclosure with their clients. However, due to the small sample size it is difficult to generalize these findings.

This finding is supported by past studies examining the topic. A national survey looking at whether self-disclosure was a technique that was being used by psychologists working in the mental health field found that 90% of therapists used the technique at some point in time (Pope et al, 1987). Another study done by Mathews (1989), involving

psychiatrists, psychologists and social workers, found that 80% of them used self-disclosure as a therapeutic technique. More examination into how this technique is being used needs to be done as many of the studies are not recent.

My second research question examined whether therapists working with children or adolescents self-disclose more than therapists working with adults. Though the statistical test was not valid due to the low number of therapists in each category, the results do appear to indicate that therapists working with children or adolescents and those working with adults self-disclose at about the same rate: 40% of therapists working with adults self-disclose rarely, while 37.5% of therapists working with children or adolescents self-disclose rarely. In contrast, 60% of therapists working with adults self-disclose sometimes and 62.5% of therapists working with children or adolescents self-disclose sometimes.

The literature suggests that in theory children and adolescents need their therapists to use self-disclosure in a different way from those working with adults. Children and adolescents are more in need of new objects to internalize than in resolving their transference (Gaines, 2003). Given this theory, I had predicted that therapists working with children and adolescents would use self-disclosure more often than therapists working with adults. However, this hypothesis was not supported and the rate of self-disclosure between therapists working with adults and therapists working with children or adolescents was not significantly different. Again, these findings can't be generalized due to the size of the sample and the inability to obtain a statistically significant result. To find out if there is no statistical difference in the rate of self-

disclosure between therapists who work with adults and therapists who work with children or adolescents a study with larger sample would need to be conducted.

My third research question looked at whether therapists with more experience in the field self-disclosed more or less to their clients. Though the results were not statistically significant, they indicate that therapists with more experience tend to self-disclose more: 56.3% of therapists with more than ten years of experience self-discloses sometimes, as compared to 38.9% of therapists with ten or fewer years of experience. It would seem that there may be a correlation between amount of years in the field and use of self-disclosure. A study done by Bishop and Lane (2002) suggested that self-disclosure was a technique best used by more experienced clinicians. Though there was no significant conclusion from my study due to low sample size, it did appear that therapists with more experience were utilizing self-disclosure more than therapists with less experience. This may be because therapists feel more comfortable using themselves as a tool once they are more comfortable with their skills as a therapist.

My fourth research question examined the effect a therapist's personal experience with their own therapist who self-disclosed on their rate of self-disclosure with their clients. Though the statistical test was unable to confirm statistical significance due to the low number of therapists in each category, the results indicate that therapists who had a therapist who self-disclosed to them had a higher rate of self-disclosure: 55.3% of therapists who had a therapist who self-disclosed to them sometimes used self-disclosure with their clients. In contrast, 40% of therapists who did not have a therapist who self-disclosed to them used self-disclosure with their clients sometimes. There appears there may be a relationship between a therapist's own experience with self-disclosure in

therapy and their use of it in their practice. However, due to the low sample size this hypothesis was not supported in this study.

There is very little literature on this topic. One study done by Simone et al. (2001) found that therapists who reported a helpful disclosure by their therapist reported that they were more likely to use self-disclosure with their own clients. Another study found that therapists who self-disclosed more had fewer hours in personal therapy (Simon, 1988). The relationship between a therapist's own therapy experience and their professional use of self-disclosure is statistically inconclusive, but given the results of my study is an area that warrants further study.

Strengths and Limitations of the Study

For this study, quantitative data was collected in the form of an anonymous internet survey over Survey Monkey. A quantitative method was chosen for its concrete and standardized nature. I was interested in seeing how therapists' utilization of the technique of self-disclosure was similar given a number of different variables including the population worked with, years in the mental health field and personal experience with therapy.

The survey asked a number of demographic questions, along with questions about the therapist's use of self-disclosure. The survey was self-constructed and posted on the website Survey Monkey. I decided to use an anonymous internet survey because I felt therapists would be more willing to share their experiences if the survey was anonymous. In addition, having the survey on the internet made it easily accessible, and meant that I was not constricted by geography. My survey was short and simple in nature which, I felt, would be more user friendly to therapists who are often already overscheduled.

The major disadvantage of the survey design was that I had no way of knowing who had filled it out and could not follow up with people. Also there was no tangible survey instrument to give people, and so I had to pass out or e-mail the link to them and hope they would go to the website. This meant that the survey was not something they could do anywhere, as they needed computer and internet access.

In terms of the sample, I do feel as though I obtained an adequate initial number of respondents. Ninety therapists responded to the on-line survey. Of those respondents, 19 did not meet the inclusion criterion of having worked in the mental health field for at least five years. Of the 72 respondents who met the inclusion criteria only 62 agreed to the informed consent.

A strength of the sample was that a wide range of ages of therapists were represented. The ages of respondents ranged from 27-65: 19% of respondents were between 25-35 years of age, 27.6% of respondents were between the ages of 36-45, 31% of respondents were between the ages of 46-55 and 22.4% of respondents were between the ages of 56-65. Having such a wide age range meant that results were not dependant on the age of the therapist. However, when examining the amount of time in the field and its correlation to a therapist's use of self-disclosure, having such a wide range of ages may have made it difficult to have enough individuals in each category to make it possible to run statistical tests.

While there were many strengths to this sample, there were also many limitations. Three important demographic characteristics were underrepresented: race, gender and professional discipline. The sample was primarily Caucasian, accounting for 91.7% of the sample. Non-Caucasian respondents represented only 8.3% of the sample. Even though

efforts were made to outreach to therapists of color, the racial make-up of the area of Western Massachusetts where most of the recruiting took place is primarily Caucasian. If this study is done again it would be important to be able to include a more racially diverse sample so that the findings could be generalized, and comparisons might be made base on ethnic/ racial variability of the participants.

Another limitation to the sample was the underrepresentation of males in the study. Females made up 78.7% of the sample, while males made up only 21.3%. No one self-reported as being transgendered though there was a category for this. The high percentage of females is not surprising, given that the mental health field is primarily still a field dominated by women.

Also, there was unbalanced representation of professional disciplines in the sample. Given that the majority of people who were outreached for this survey were social workers, it is not surprising that they compromised the majority of the sample. Social workers made up 72.9% of the sample, with psychologists and mental health counselors each making up 13.6% of the sample respectively. Given that the sample was one of convenience, the connections that I utilized to obtain participants for the survey were mostly clinical social workers. Having a more diverse sample in regards to professional discipline may significantly alter the findings, as different disciplines often have very different beliefs about and approaches to the use of self-disclosure in therapy.

Another difficulty with the study was the way the central question of how often therapists self-disclosed was measured. The question was asked twice, and though the results were similar both times, each question used a different way to measure the outcome. The first time the question was posed, the majority, 54.1% of respondents said

they used the technique periodically. The second time the question was asked, the majority 51.0% of respondents said they used the technique sometimes. The question was asked using two different scales of measurement to see if there was a consistency in the way people answered the question. However, this seemed to confuse people and many people simply skipped the question the second time it was posed. In addition, the scales themselves may not have been the most efficient way to elicit the information that was being sought. There was very little previously published literature that had a tested scale for frequency of therapist self-disclosure. Most scales that were used in the past were examining a client's perceptions of therapist self-disclosure rather than the therapist's *practice* of self disclosure. It may have been more effective to research previous scales and change them to measure the therapist's experience, rather than attempting to create a whole new way of measuring therapist self-disclosure.

Implications for Practice

Self-disclosure is a powerful therapeutic technique that can be very effective when it is done skillfully and thoughtfully. Though the results in this study were not statistically significant, they did point to the reality that therapists are using self-disclosure at a high rate. It is important that faculty in professional training programs and supervisors of therapists in the field are aware of this and give adequate support and training. Many disciplines discourage use of self in the therapeutic process. Though these approaches are becoming less prevalent, many people practicing in the field today were trained when self-disclosure on the part of the clinician was a taboo. It is vital that therapists have an open dialogue about the use of self –disclosure.

Implications for Future Research

Though because of the small sample there were no statistically significant results from this study, the issues raised should be explored further. Self-disclosure is a technique that is being used by most therapists. A better understanding of why and when therapists should self-disclose is an important part of understanding of how best to use this often controversial technique.

A larger scale study that has a more diverse pool of participants may demonstrate significant results that could further inform the profession. A more effective scale for measuring therapist self-disclosure needs to be created and tested in order to get a more accurate picture of how often therapists are using self-disclosure with their clients.

Conclusion

The therapeutic relationship is a fundamental tool of good clinical practice. However, how and when to use self-disclosure is widely debated within the mental health field. Historically psychoanalysis had strict boundaries that were erected so that the therapist was nothing more than a mirror reflecting back only what the client put out. This traditional view has been challenged by a newer relational approach to therapy. This approach believes that healing is not achieved through insight alone, but rather through what is discovered in a new “relational experience” (Bishop and Lane, 2002). What takes place between the therapist and client can be as important as the topics discussed. The therapist reveals themselves unintentionally and intentionally by the questions asked and those left unattended to, by the connections made and those left aside and by the inadvertent or intentional displays of emotion in each interaction (Bishop and Lane, 2002). While self-disclosure is a powerful and at times crucial tool to utilize, it is also one

that must be used with the utmost care. There needs to be room made, in training programs, supervision and continuing education, for an on-going dialogue about the use of self-disclosure to happen.

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APPENDIX A



Smith College
Northampton, Massachusetts 01063
Phone: 413/545-7000
Fax: 413/545-7000

March 3, 2010

Allyson Mazzuchi

Dear Allyson,

Your revised materials have been reviewed. They are fine, although we still think you should remove that sentence beginning with "I assume..." in paragraph three of the Consent. It just sounds slightly condescending and is unnecessary. We doubt if you will be able to use NASW or APA web sites.

Please note the following requirements.

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ann Hartman'.

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Michael Murphy, Research Advisor

I need your help!!!

*I am a student at the Smith College School for
Social Work*

**I'm Looking for therapists
for an anonymous survey
examining therapists'
current views and use of
self-disclosure in their
work.**

Therapists need to have a minimum of five
years experience in the mental health field

This should take at the most 30 minutes of
your time. Just click on this Survey link:

**[www.surveymonkey.com/s/therapist-self-
disclosure](http://www.surveymonkey.com/s/therapist-self-disclosure)**

Questions or comments? Please contact
Allyson Mazzuchi: amazzuch@smith.edu

APPENDIX C

1. Have you worked as a therapist in the mental health field for five years or more?

Yes ☒ No ☐

Smith College School for Social Work

Dear Participant:

My name is Allyson Mazzuchi. I am a graduate student at Smith College School for Social work. I am writing to ask for your help in completing a brief survey that is for my master's thesis. The overall purpose of the study is to explore the current views of self-disclosure by therapists currently working in the field. The data collected will be used for my master's of social work thesis, and in possible professional publications and presentations. The criteria for participating in the survey is that you have been practicing in the mental health field for at least five years. You will be asked to answer a series of ten demographic questions. You will then be asked to answer several questions about your use of self-disclosure. The survey should take no more than ten to fifteen minutes, though if you choose to elaborate in the dialogue boxes provided, it could take somewhat longer. There is a small risk that by participating in my survey you might feel somewhat uncomfortable recounting times that you used self-disclosure, especially if it resulted in a negative outcome for a client. You may benefit from participating in the study by being able to reflect on your use of intentional self-disclosure and the effect it has had on your relationships with your clients. I hope there will be a benefit to therapists as a group in terms of how self-disclosure affects the therapeutic alliance. There will be no compensation provided for your participation in this study. Your participation and your responses to this study will be anonymous, as I will not know your identity; the on-line survey provider removes all identifying information about respondents before sending the surveys to me. The only people who will access to the survey information besides myself, will be my advisor and the statistical analyst at Smith College, and again, no identifying information will be attached to your responses. The data that are collected will be kept for up to three years as required by Federal guidelines and will password protected. In publication or presentation, data will be presented as a whole, and when brief illustrative quotes are used they will be carefully disguised. Your participation in this study is voluntary and you may discontinue your participation at any time without penalty. You may choose not to answer any questions you wish, including demographic questions. Once you have hit on the "submit" button your information cannot be withdrawn, as I will have no way of knowing which information is yours. If you have any questions or concerns please contact me at amazzuch@smith.edu or the Chair of the Smith College School for Social Work Human Subject Review Committee at (413) 585-7974. Please print a copy of this consent form for your records. Thank you for your participation in this study.

By checking "I agree" below you are indicating that you have read and understood the information above and that you have had a chance to ask any questions about the study, your participation and that you agree to participate in the study.

I agree ☒ I don't agree ☐

1. What is your gender?

Male _____

Female _____

Transgendered _____

2. What is your age?

3. What is your racial/ethnic identification?

Caucasian

African-American _____

Asian _____

Native-American _____

Latino/Hispanic _____

Other (please specify) _____

4. What is your highest level of education?

Some high school _____

High school/GED _____

Some college _____

Bachelor's degree _____

Masters degree _____

Doctoral degree _____

5. What is your professional discipline?

Psychologist _____

Social Worker _____

Mental health counselor _____

Substance abuse counselor _____

Other (please specify) _____

6. If you have a professional license what is it?

7. How long have you been working in the mental health field?

8. What mental health setting do you primarily work in?

Outpatient clinic _____

Outpatient private practice _____

Residential program _____

Case management _____

9. What population do you work with the most? (check all that apply)

Outpatient clinic

Children 0-12 _____

Adolescents 13-19 _____

Adults 20-64 _____

Older Adults 65 and over _____

The definition of self-disclosure for the purposes of this study will be intentional revelations about the therapist's self or his or her subjective reactions to the client.

1. How often, if ever, do you self-disclose with clients?

Often _____

Periodically _____

Rarely _____

Never _____

2. How often do you self-disclose with clients?

Never _____

Rarely _____

Sometimes _____

Always _____

3. Do you use self-disclosure more often:

In the beginning of treatment _____

During the middle of treatment _____

Near the end of treatment _____

4. As compared to when you first began working in the mental health field how often do you self-disclose now?

Extremely less often _____

Somewhat less often _____

Somewhat more often _____

Extremely more often _____

5a. Do you self-disclose with clients who are the same sex as you:

Never _____

Rarely _____

Sometimes _____

Always _____

5b. Do you self-disclose with clients who are the opposite sex as you:

Never _____
Rarely _____
Sometimes _____
Always _____

6. When you engage in self-disclosure how often do those self-disclosures consist of:

Factual information about yourself:

Never _____
Rarely _____
Sometimes _____
Always _____

Feelings or events in your own life:

Never _____
Rarely _____
Sometimes _____
Always _____

Feelings about or towards the client:

Never _____
Rarely _____
Sometimes _____
Always _____

Other (please specify) _____

7. In your training program were there classes or lectures about the use of self-disclosure?

Yes _____
No _____

8. Have you ever been in therapy?

Yes _____
No _____

9. Did your therapist self-disclose to you?

Yes _____
No _____

10 . If yes how did it affect your working relationship?

Positively _____

Negatively _____

Neither _____

Please elaborate:

Non self -disclosing therapists:

1. Why do you not self-disclose in your work with your clients?

There are better techniques:

Strongly disagree _____

Disagree _____

Agree _____

Strongly Agree _____

It is harmful to the client

Strongly disagree _____

Disagree _____

Agree _____

Strongly Agree _____

I had a bad experience

Strongly disagree _____

Disagree _____

Agree _____

Strongly Agree _____

Other (please specify)

2. In your training program were there classes or lectures about the use of self-disclosure?

Yes _____

No _____

3. Have you ever been in therapy?

Yes _____

No _____

4. Did your therapist self-disclose to you?

Yes _____

No _____

5. If yes how did it affect your working relationship?

Positively _____

Negatively _____

Neither _____

Please elaborate:

Thank you for your time

APPENDIX D

Smith College School for Social Work

Dear Participant:

My name is Allyson Mazzuchi. I am a graduate student at Smith College School for Social Work. I am writing to ask for your help in completing a brief survey that will be used for my master's thesis. The overall purpose of my study is to explore the current views of therapist self-disclosure by therapists currently working in the field. The data collected will be used for my master's of social work thesis, and in possible professional publications and presentations.

Criteria for participation in this survey include that you have practiced as a therapist in the mental health field for five years or more. You will be asked to answer several questions about your use of self-disclosure. There are also a series of ten demographic questions. The survey should take no more than ten to fifteen minutes, though if you choose to elaborate in the dialog boxes provided, the survey will take somewhat longer.

There is a small risk that by participating in my survey you might feel somewhat uncomfortable recounting times that you used self-disclosure, especially if it resulted in a negative outcome with a client. You may benefit from participating in the study by being able to reflect on your use of intentional self-disclosure and the effects it has had on your relationship with your clients. I hope there will be benefit to therapists as a group in terms of a better understanding of how self-disclosure affects the therapeutic alliance. There will be no compensation provided for participating in this study.

Your participation and your responses to this study will be anonymous, as I will not know your identity; the on-line survey provider removes all identifying information about respondents before sending the surveys to me. The only people with access to survey information besides myself will be my advisor and the statistical analyst at Smith College, and again, no identifying information will be attached to your responses. The data that are collected will be kept for up to three years as required by Federal guidelines and will be password protected. In publications or presentations, data will be presented as a whole, and when brief illustrative quotes are used they will be carefully disguised.

Your participation in this study is voluntary and you may discontinue your participation at any time without penalty. You may choose not to answer any questions you wish, including demographic questions. Once you have clicked on the "submit" button your information cannot be withdrawn, as I will have no way of knowing which information is yours. If you have any questions or concerns please contact me at amazzuch@smith.edu or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY CHECKING "I AGREE" BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print out a copy of this Consent Statement for your records.

Thank you very much for your participation in this study!